STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A DUIL DING	00	COMPLETED	
155089		A. BUILDING B. WING		04/09/2012	
NAME OF PROVIDER OR SUPPLIER HERITAGE HOUSE OF NEW CASTLE			STREET 1023 N	ADDRESS, CITY, STATE, ZIP CODE I 20TH ST CASTLE, IN 47362	
				1	(7/5)
(X4) ID PREFIX		STATEMENT OF DEFICIENCIES NCY MUST BE PERCEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5) COMPLETION
TAG	`	R LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE DATE
F0000	NEGOZIII ONI O	New Medical Control of the Control o			
F0000	State Licensure	pril 2, 3, 4, 5, and 9, 2012 r: 000035 er: 155089 100266250 EN TC RN N on RN e:	F0000	Preparation and/or execution This Plan of Correction in ger or any corrective action set fo herein, in particular, does not constitute an admission or agreement by Heritage House New Castle of the facts allege the conclusions set forth in th statement of deficiencies. Th Plan of Correction and specific corrective actions are prepare and/or executed solely becau of provisions of federal and/or state laws. Heritage House desires this F of Correction to be considered facility's Allegation of Compliance. Compliance is effective April 24, 2012	neral rth e of ed or e e c c ed se
	These deficienc	•			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any defiency statement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A BIIII	LDING	00	COMPLETED	
		155089	B. WIN			04/09/	2012
			B. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER				20TH ST		
HERITAC	GE HOUSE OF NEV	V CASTLE			ASTLE, IN 47362		
(X4) ID	SUMMARY S	FATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F0282 SS=D	483.20(k)(3)(ii) SERVICES BY COME PLAN The services profacility must be point accordance with plan of care. Based on obset record review, follow the care planned intervention of 19 residents.	QUALIFIED PERSONS/PER vided or arranged by the provided by qualified persons with each resident's written rvation, interview and the facility failed to plan related to pentions to prevent falls, dents reviewed for care ent #34)	F02		F 282 1. Resident #34 had bolsters added to his bed on April 17, 2012. 2. All resident's care plans will reviewed by the MDS/care pla coordinators to identify any resident who has bolsters care planned. All residents who ha bolsters care planned will be	n :	04/24/2012
		Resident #34 was /3/12 at 1:46 p.m.			assessed to ensure the bolste are in place correctly by the MDS/care plan nurses. 3. A daily audit for adaptive	rs	
	Resident #34 r	nost recent, MDS			equipment, identified in the cal	re	
		ta Set), assessment,			plan, will be done by nursing. I		
	dated 3/14/12,	,,			any resident is found to not ha		
	· · · · · · · · · · · · · · · · · · ·	murated the			bolsters, as had previously bedidentified in the care plan, the	311	
	following:				nurse doing the audit will revie	w	
	- BIMS (Brief	Interview of Mental			the care plan to see if an upda		
	Status) 15. The	e range of 13-15			has been done. The nurse will		
	· ·	dent's cognition was			also meet with the MDS/care p		
	intact.				nurse to discuss any updates of		
	- transfer, activity	y did not occur			changes made to the care plant See attachment #1.	1.	
					4. A daily audit for adaptive		
		r corridor, activity did			equipment to include bolsters	will	
	not occur				be done daily by nursing. The		
	- falls, yes				nurse who does the audit for		
		are plan, dated 3/14/12, m, resident has multiple			adaptive equipment will report findings to the QA Committee one yr., at 3 mo. 6 mo. and at mos. Any recommendations w	for 12	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: K6W611

Facility ID: 000035

If continuation sheet Page 2 of 10

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S		
AND PLAN	AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155089		A. BUI	LDING	00	COMPLI 04/09/2	
133009			B. WIN			04/09/	2012
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
HERITAC	GE HOUSE OF NEV	N CASTLE			20TH ST ASTLE, IN 47362		
					7.0122, IIV 17002	ı	(V5)
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	DATE
	risk factors for fa	alls. Goal, resident will			be followed. This will be		
	sustain no injurie	es due to falls.			monitored by the Director of		
	Interventions, in	cluded but were not			Nursing. Completion date April, 24, 201	2	
	limited to orient	resident to surroundings,				_	
	_	or resident frequently					
	~	s not available, bolsters					
		eep bolsters covered with					
	_	nt check placement of					
		sheet for optimum					
	safety.						
	D :1	1 . 1					
		s nursing notes, dated					
		5 a.m., indicated					
	"resident foun	d on floor beside bed.					
	Stated he was	getting up, did not hit					
	his head. Sitti	ng with left leg bent					
	behind thigh.	New order for x-ray					
	per physician.	•					
	per priyereran.						
	 During an obs	ervation on 4/4/12 at					
	_	sident #34 was					
		ed and he did not					
	nave doisters i	n place on his bed.					
	D	: '4 DNI //1					
	_	erview with RN #1 on					
	4/4/12 at 10:24	· · · · · · · · · · · · · · · · · · ·					
	indicated Resi	dent #34 did not have					
	bolsters on his	bed. She also					
	indicated Resi	dent #34 gets					
		etimes and forgets he					
		<i>5</i>					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: K6W611

Facility ID: 000035

If continuation sheet Page 3 of 10

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155089		ĺ	LDING	NSTRUCTION 00	(X3) DATE (COMPL 04/09/	ETED	
	PROVIDER OR SUPPLIE			STREET A 1023 N	ADDRESS, CITY, STATE, ZIP CODE 20TH ST ASTLE, IN 47362		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	said," 'I am go the bathroom he could not v During an obs 10:50 a.m., R observed in b his bed During an int (Director of N 10:55 a.m. Sh not sure why on Resident # different matt the bolsters w bolsters woul The DON als procedure in be informed or residents such to have bolster CNAs are ins	st like this morning he bing to get up and go "and I reminded him walk." servation on 4/9/12 at esident #34 was ed without bolsters on erview with the DON Jursing) on 4/9/12 at the indicated she was the bolsters were not 34's bed but he has a ress than he had when there on his bed so the donot fit this mattress. To indicated the which the CNAs are to of interventions for an as what residents are the sers on their bed is the tructed to read and ident's care plans.					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: K6W611

Facility ID: 000035

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/27/2012 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155089		(X2) MULTIPL A. BUILDING B. WING	E CONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 04/09/2012	
NAME OF I	PROVIDER OR SUPPLIEF	<u> </u>	STRE	EET ADDRESS, CITY, STATE, ZIP CODE	
HERITA	GE HOUSE OF NE	W CASTLE		3 N 20TH ST W CASTLE, IN 47362	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	CROSS-REFERENCED TO THE APPROPR	E COMPLETION

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: K6W611

Facility ID: 000035

If continuation sheet Page 5 of 10

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00			COMPLETED	
		155089	B. WIN			04/09/2	2012
(F. 0F. P				STREET A	ADDRESS, CITY, STATE, ZIP CODE	L	
NAME OF P	PROVIDER OR SUPPLIER			1023 N	20TH ST		
HERITAC	GE HOUSE OF NEV	V CASTLE		NEW C	ASTLE, IN 47362		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	``	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	re	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	+	TAG	DEFICIENCE		DATE
F0323 SS=D	483.25(h) FREE OF ACCIE	DENT					
33-0		ERVISION/DEVICES					
		ensure that the resident					
		nains as free of accident					
	· ·	ssible; and each resident					
		te supervision and es to prevent accidents.					
	Based on obse	rvation, interview and	F03	23			04/24/2012
		the facility failed to			F323		
	· ·	ined interventions to					
		r 1 of 3 residents			1. Resident #34 had bolsters		
	reviewed for fal				added to his bed on April 17,		
		(**************************************			2012.		
	Findings include:				2. All resident's care plans will		
					reviewed by the MDS/care pla	n	
	The record of	Resident #34 was			coordinators to identify any resident who has bolsters care	<u> </u>	
		/3/12 at 1:46 p.m.			planned. All residents who ha		
		diagnoses included			bolsters care planned will be		
		mited to seizures,			assessed to ensure the bolster are in place correctly by the	îS	
		· · · · · · · · · · · · · · · · · · ·			MDS/care plan nurses.		
	_	osis, subarachnoid			3. A daily audit for adaptive		
	hemorrhage (b	leeding into the area			equipment, identified in the ca		
	between the br	rain and the tissues			plan, will be done by nursing. I any resident is found to not ha		
	that cover it), s	stroke, anemia,			bolsters, as had previously be		
	· · · · · · · · · · · · · · · · · · ·	cute kidney failure.			identified in the care plan, the		
	acimiam ana a	cate Ridney Turidre.			nurse doing the audit will revie		
					the care plan to see if an upda		
		most recent, MDS			has been done. The nurse will also meet with the MDS/care p		
	(Minimum Da	ta Set), assessment,			nurse to discuss any updates		
	dated 3/14/12,	indicated the			changes made to the care plan		
	following:				See attachment #1.		
		f Interview of Montal			4. A daily audit for adaptive	الني	
	,	f Interview of Mental			equipment to include bolsters be done daily by nursing. The	WIII	
	Status) 15. The	•			nurse who does the audit for		
	indicated the resi	ident's cognition was			adaptive equipment will report	her	

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Event ID: K6W611

Facility ID: 000035

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MU	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A RIIII	A. BUILDING 00			COMPLETED	
	155089		B. WINC			04/09/	2012
NAME OF B	DROWDER OF CURRY			STREET A	ADDRESS, CITY, STATE, ZIP CODE	•	
NAME OF P	PROVIDER OR SUPPLIE	K		1023 N	20TH ST		
HERITAC	GE HOUSE OF NE	W CASTLE		NEW C	ASTLE, IN 47362		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		NCY MUST BE PERCEDED BY FULL] 1	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE.	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION)		TAG	·	for	DATE
	intact.				findings to the QA Committee one yr., at 3 mo. 6 mo. and at		
	- transfer, activi				mos. Any recommendations w		
		or corridor, activity did			be followed. This will be		
	not occur				monitored by the Director of		
	- falls, yes				Nursing. Completion date April, 24, 20	12	
					Completion date April, 24, 20	14	
		are plan, dated 3/14/12,					
		m, resident has multiple					
	risk factors for f	falls. Goal, resident will					
	sustain no injuri	es due to falls.					
	Interventions, in	cluded but were not					
	limited to orient	resident to surroundings,					
	call light, monit	or resident frequently					
	when call light i	s not available, bolsters					
	placed on bed, k	eep bolsters covered with					
	linen and freque	nt check placement of					
	bolsters and ove	r sheet for optimum					
	safety.	-					
		Fall Risk Assessment",					
	dated 4/6/12, inc	dicated the following:					
	- level of consci	ousness/mental status,					
	intermittent con	fusion, total 4					
	- history of falls	, 1-2 falls in past 3					
	months, total 2						
	- ambulation/eli	mination status, chair					
	bound-requires	restraints and assist with					
	elimination						
	- vision status, a	dequate, total 2					
		akes 3 -4 of these					
	·	rently and/or within last 7					
	days (narcotics,	•					
	1						
		iseases, 1 -2 present, total					
	when call light in placed on bed, keep linen and frequent bolsters and over safety. Resident #34's "dated 4/6/12, incomplete of consciplination of the place of	s not available, bolsters teep bolsters covered with int check placement of r sheet for optimum Fall Risk Assessment", dicated the following: ousness/mental status, fusion, total 4 , 1-2 falls in past 3 mination status, chair restraints and assist with dequate, total 2 takes 3 -4 of these rently and/or within last 7 psychotropic, e), total 4					

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Event ID: K6W611

Facility ID: 000035

If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE ((X3) DATE SURVEY COMPLETED
AND PLAN	OF CORRECTION	155089	A. BUILDING	00	04/09/2012
			B. WING	Γ ADDRESS, CITY, STATE, ZIP CODE	0 1/00/2012
NAME OF I	PROVIDER OR SUPPLIEF	2		N 20TH ST	
HERITAG	GE HOUSE OF NE	W CASTLE	NEW	CASTLE, IN 47362	
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX TAG	`	ICY MUST BE PERCEDED BY FULL LISC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	
ing	2	LESC IDENTIFICATION OR MATTERLY	1710		DATE
		vith a total score above 10			
	represents high r				
		s nursing notes, dated			
		5 a.m., indicated			
		d on floor beside bed.			
		getting up, did not hit			
	his head. Sitti	ng with left leg bent			
	behind thigh.	New order for x-ray			
	per physician.				
	Resident #34's	s, left knee x-ray,			
	indicated "Res	sults: There is a			
	fracture involv	ving left distal femur			
	with medial di	isplacement."			
	During an obs	ervation on 4/4/12 at			
	10:00 a.m. Re	sident #34 was			
	observed in be	ed and he did not			
	have bolsters	in place on his bed.			
	During an inte	erview with RN #1 on			
	4/4/12 at 10:2	4 a.m., RN # 1			
	indicated Resi	dent #34 did not have			
	bolsters on his	s bed. She also			
	indicated Resi	dent #34 gets			
	confused some	etimes and forgets he			
	can't walk "jus	st like this morning he			
	said," 'I am go	oing to get up and go			

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Event ID: K6W611

Facility ID: 000035

If continuation sheet Page 8 of 10

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE C		(X3) DATE SURVEY
AND PLAN	OF CORRECTION	155089	A. BUILDING	00	COMPLETED 04/09/2012
100000			B. WING	ADDRESS CITY STATE 7ID CORE	371001201Z
NAME OF I	PROVIDER OR SUPPLIEF	R		ADDRESS, CITY, STATE, ZIP CODE	
HERITAG	GE HOUSE OF NE	W CASTLE		CASTLE, IN 47362	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	ICY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
TAG		LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
		"and I reminded him			
	he could not w	valk."			
	D	4/0/12 -4			
	_	ervation on 4/9/12 at			
	•	esident #34 was			
		ed without bolsters on			
	his bed				
	Daning	ami am mith the DOM			
		erview with the DON			
	,	fursing) on 4/9/12 at			
	•	ne indicated she was			
	I	the bolsters were not			
	on Resident #3	34's bed but he has a			
	different matti	ress than he had when			
	the bolsters w	here on his bed so the			
	bolsters would	d not fit this mattress.			
	The DON also	indicated the			
	procedure in v	which the CNAs are to			
	be informed o	f interventions for			
	residents such	as what residents are			
	to have bolste	rs on their bed is the			
		ructed to read and			
		ident's care plans.			
		1			
	3.1-45(a)(2)				
	- (/(-)				

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Event ID: K6W611

Facility ID: 000035

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/27/2012 FORM APPROVED OMB NO. 0938-0391

		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO		(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: 155089	A. BUILDING	00	COMPLETED 04/09/2012
		100008	B. WING	A D D D D D D D D D D D D D D D D D D D	04/03/2012
NAME OF P	PROVIDER OR SUPPLIE	R		ADDRESS, CITY, STATE, ZIP CODE	
HERITAC	GE HOUSE OF NE	W CASTLE		20TH ST ASTLE, IN 47362	
				I	
(X4) ID PREFIX		STATEMENT OF DEFICIENCIES NCY MUST BE PERCEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5) COMPLETION
TAG		R LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	DATE
		,			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: K6W611

Facility ID: 000035

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